Life & Times

Weight bias and stigmatisation:

what is it and what can we do about it?

Weight bias has been described as the last acceptable form of prejudice. When translated to the consultation room it becomes a health threat in itself, risking inequality of care and hindering the intervention and adherence efforts of both physicians and patients.

In the 2015 *BMJ* article entitled 'Why there's no point telling me to lose weight', a patient criticises GPs' preoccupation with body weight over concurrent health issues in consultations. The author asserts, *'my GP … sees me as a fat person first and an individual second'*.[1] Indeed, studies have proven weight bias, both implicit and enacted, to be rife in healthcare settings. To optimise patient care, it is important to understand the barriers to quality health care posed by implicit physician attitudes and to look towards solutions.

THE STIGMATISED PATIENT

Studies show that patients with higher BMIs are less respected than patients with a healthy weight, and physicians report seeing patients who are obese as less compliant and self-disciplined, their desire to intervene declining as patient BMI increases.[2,3] This attitude arguably stems from perceptions of the controllability of obesity; the problematic view of patients who are obese as 'architects of their own health' informs a reluctance to encourage lifestyle change, despite stigmatisation itself having been shown to reinforce lifestyle behaviours that contribute to obesity.

GPs are less likely to engage in patient-centred communication and build rapport with patients who are obese, whom they believe will show poor adherence, and consultation time may be allocated differently, with less time spent educating patients about their health.[4,5] Physicians may also over-attribute patients' medical problems to obesity; appropriate referrals therefore may not be made and treatments other than weight loss are not explored.

Stigma, being a form of social rejection, can cause depression, anxiety, and lowered self-esteem. Further, patients who feel stigmatised can develop anxieties over seeking health care and therefore delay or avoid it entirely. The psychological stress of experienced stigmatisation can itself contribute to the pathophysiology of overweight, for example, stress-induced changes to endocrine function result in increased cortisol, fatty acids, blood sugar, and LDL levels. Patients who feel stigmatised are likely to discount feedback, and studies show that those who experience more obesity stigma place a lower value on health.[6] Hence, enacted weight bias can directly preclude the success of health interventions for patients who are obese and overweight.

So what can primary care practitioners do? It is our responsibility to identify and challenge our own biases and ensure they do not affect our clinical practice. Harvard's 'Project Implicit' Association Test is a quick and easy tool to elucidate implicit biases.[7] Previous studies concerned with reducing bias have successfully trialled perspective-taking exercises, acceptance and commitment therapy, and other exercises that promote positive mental attitude and emotion, which were linked to prosocial behaviours and reduced prejudice.[8–10]

Obesity stigma specifically, however, has proven particularly resistant to interventions versus other types of prejudice. Furthermore, primary care practitioners have little time to commit to intensive and prolonged participatory training courses.

Of those interventions that have targeted weight and obesity bias specifically, the most successful have been educative. A 2010 study in which healthcare students received tutorials on the causes of obesity found that improving the participants' understanding of genetic and environmental influences in particular led to a reduction in implicit 'anti-fat' attitudes.[11] Similarly, a 2013 trial in which brief anti-stigma films were shown to trainee doctors was found to significantly reduce explicit attitudes and beliefs towards people who are obese.[12] Perhaps, therefore, a greater effort to include brief educative interventions in medical school and trainee curricula should be made.

TAKING RESPONSIBILITY

Ultimately, stigma and enacted bias affect clinical conduct and are counterproductive to encouraging positive behaviour change. If present, implicit cognitive biases must not affect practitioner behaviour to ensure equal and effective consultation practice, to protect patient safety, and to maximise the success of behaviour change interventions. We as a community dedicated to curative and preventive measures should be diligent in finding ways to lessen the phenomenon of weight bias.

Addressing a patient's primary presenting complaint should be first priority in the consultation; never assume that a patient needs weight loss advice, or that they want to lose weight. Patient–clinician rapport is consequently improved. To directly combat bias, incorporating bias awareness exercises into medical training, including the pre-clinical curricula, will help health practitioners to identify and curb their own implicit biases.

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